

# Louisiana State Board of Medical Examiners

Physical Address: 630 Camp Street, New Orleans, LA 70130  
Mailing Address: P.O. Box 30250, New Orleans, LA 70190-0250  
Phone: (504) 568-6820, Fax: (504) 568-0503



## ***POLYSOMNOGRAPHY INSTRUCTIONS***

*(Rev. 051706)*

The board may issue a Polysomnography license or a Polysomnography Provisional Permit to an individual for the purpose of practicing Polysomnography.

### **QUALIFICATIONS FOR PERMIT**

- Be of good moral character
- Be a citizen of the United States or possess valid and current legal authority to reside and work in the United States duly issued by the commissioner of the Immigration and Naturalization Service
- Is licensed as a Polysomnographer under the laws of another state, territory, or country, whose standards of licensure conform with the standards of this state on that date. (Original license must be presented).
- Holds current credentials as a registered polysomnographic technologist granted by the Board of Registered Polysomnographic Technologists or equivalent organization.
- Pay the appropriate fee: Technologist - \$150.00; Technician - \$100.00; Training - \$50.00

**Note: Fees are not refundable.**

### **GENERAL INFORMATION**

The state of Louisiana does criminal background checks as part of the application process through the state -Louisiana Department of Public Safety and Corrections-DOC and Federal Bureau of Investigations-FBI. Materials for this purpose can be obtained by writing to:

LSBME-Attn: CB  
P O Box 30250  
New Orleans, LA 70190-0250

Or by e-mail at [lsbmemat@lsbme.louisiana.gov](mailto:lsbmemat@lsbme.louisiana.gov)

Applicants with criminal history may expect delays in the application process.

### **Certified Birth Certificate**

The applicant must submit either a certified birth certificate (a certified document can only be obtained from the issuing agency and must bear the official seal or stamp and signature of an authorized representative) or an original passport (expired passports are acceptable). The certified birth certificate becomes a permanent part of the applicant's file and is not returned. If the applicant submits a passport, the applicant must include a written explanation of the reason the birth certificate is not available.

**Valid Visa**

Applicants who are not native-born citizens of the United States must show proof of legal entry into the United States to work and reside by presenting either:

- An original certificate of Naturalization
- Certified birth certificate establishing birth to U.S. citizens traveling abroad
- Valid Visa issued by the department of Immigration and Naturalization (INS). (Acceptable visas – J-1, H-1B, Immigrant)

**Personal Appearance**

A personal appearance with a member of the Louisiana State Board of Medical Examiners (the “Board”) or its designee is required of each applicant. Personal appearances are by appointments only and can only be scheduled after receipt of ALL application materials. At the time of the personal appearance, you must present the ORIGINAL of the following documents (copies should have already been provided). All documents submitted to the board must be the original and must be in English. If the document(s) is not in English, they must be accompanied by a translation into English certified by a translator other than the applicant who shall attest to the accuracy of such translation under penalty of the law.

- Original Certificate Issued by the Board of Registered Polysomnography Technology
- Original License from other state, if applicable
- Valid Visa, if applicable

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**MUST BE TYPED OR  
BLOCK PRINTED**

**ATTACH PHOTO HERE**

## POLYSOMNOGRAPHY LICENSURE APPLICATION

Check One    \_\_\_\_    Technologist    \_\_\_\_    Technician    \_\_\_\_    Training

Name: Last				First				Middle				Suffix (Sr., Jr.)				
List all names in which you have ever been known:																
Social Security Number						Driver's License Number & State						From:                      To:				
Addresses	Business Address							City				State				
		Zip + 4		County/Parish		Country if not U.S.		Telephone (Area code, #, Ext.)				Pager Number				
	Home Address	Street & Number						City				State				
		Zip + 4		County/Parish		Country if not U.S.		Telephone (Area code, number).								
	Preferred Mailing Address	Street Number or Post Office Box						City				State				
		Zip + 4		County/Parish		Country if not U.S.		Telephone (Area code, #, Ext.)				Pager Number				
Identification		Race		Sex	Weight		Height		Eyes		Hair		Marks			
Birth  (must submit ORIGINAL or Notarized Copy of birth certificate)	Place						Date				Are you a U.S. Citizen?					
	If not native born citizen of the U.S., give the following information:						Type of visa:									
							If Naturalized, give certificate number:									
							INS number:									
							Petition number:									
							Date issued:									
	District court through which issued:															
Marital Status		Spouses First Name:				Last Name (if different from yours)										
U.S. Active Duty		Branch				Dates Served: From:                      To:								Discharge		
Check box indicating the appropriate information regarding your application		<input type="checkbox"/> This is the first time I have made application for licensure in LA. <input type="checkbox"/> I have previously made application and am licensed as a _____. <input type="checkbox"/> My application was previously denied. I am reapplying since I have fulfilled additional requirements. <input type="checkbox"/> Other: _____														

Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Education			Specialized Training (Residency, professional training, vocational training, practical/clinical training)		
High School			Institution		
City, State & Country, if not U.S.			City, State & Country, if not U.S.		
Month/Year Started	Month/Year Graduated		Month/Year Started	Month/Year Ended	Degree Earned
College/University			Institution		
City, State & Country, if not U.S.			City, State & Country, if not U.S.		
Month/Year Started	Month/ Year Ended	Degree	Month/Year Started	Month/Year Ended	Degree Earned
Professional School			Institution		
City, State & Country, if not U.S.			City, State & Country, if not U.S.		
Month/Year Started	Month/ Year Ended	Degree	Month/Year Started	Month/ Year Ended	Specialty
Work History and Non-Professional Activity Account for ALL time not specified above, in chronological order, from High School to the present.					
Name of Business/Institution			Job Title		
Street Address                      City , State Zip Code			Description of Duties Performed		
Supervisor Name			Hours worked per week		
Date of Employment From ____/____/____ To ____/____/____ Month   Day   Year                      Month   Day   Year			Type of Employment <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time		
Name of Business/Institution			Job Title		
Street Address                      City , State Zip Code			Description of Duties Performed		
Supervisor Name			Hours worked per week :		
Date of Employment From ____/____/____ To ____/____/____ Month   Day   Year                      Month   Day   Year			Type of Employment <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time		
ATTACH ADDITIONAL PAGES IF NECESSARY					
States in which license/certificate obtained and basis of licensure/certification					



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## OATH OR AFFIRMATION

### ANSWER THE FOLLOWING QUESTIONS (YES ANSWERS MUST BE EXPLAINED IN SWORN AFFIDAVIT)

	YES	NO
1. In the five years prior to this application, have you had any physical injury or disease or mental illness or impairment, which could reasonably be expected to affect your ability to practice medicine or other health profession?		
2. In the five years prior to this application, have you been addicted to or used in excess any drug or chemical substance including alcohol or treated through a drug or alcohol rehabilitation program?		
3. Have you ever, either as an adult or juvenile, been cited, arrested, charged, convicted or pled nolo contendere to, violation of any: a) State statute? b) Federal statute?		
4. Has your application for examination or license ever been rejected or denied?		
5. Have you ever failed a licensure/certification examination? If yes, how many times? _____		
6. Have you ever been denied membership in a state, county, or local professional society?	N/A	N/A
7. Has your membership in a state, county, or local professional society ever been revoked, suspended, placed on probation, or restricted in any manner?	N/A	N/A
8. Have you ever been denied, had suspended, revoked or restricted, or voluntarily relinquished, staff or clinical privileges in any hospital or other health care institution or organization?		
9. Have you had any malpractice claims filed, settled or adjudicated against you within the last five (5) years?		
10. Have you ever voluntarily surrendered, or did you have suspended, revoked or restricted, your narcotics controlled substances license or registration (state or federal)?	N/A	N/A
11. Have you ever voluntarily surrendered, or did you have suspended, revoked, placed on probation, or restricted in any manner, any professional license issued by any licensing authority?		
12. Have you ever been the subject of any type of disciplinary action or inquiry by any licensing agency, hospital, institution, society, etc.?		
13. Have you ever agreed not to seek re-licensure in any licensing jurisdiction?		
14. Have you ever been, or are you currently in the process of being denied, terminated, suspended, refused, limited, placed on probation or placed under other disciplinary action with respect to your participation in any private, state, or federal health insurance program (e.g., Medicare, Medicaid)?		
15. Has any court determined you are currently in violation of a court's judgment or order for the support of dependent children?		

## OATH OR AFFIRMATION OF APPLICANT

I HEREBY swear or affirm that all statements made and information provided in or with this application are true, correct and complete; that I am the person named in the credentials herewith presented and that I am the original and lawful possessor of such documents; that the photograph submitted to LSBME is a true likeness of me and that it was taken within the last 60 days; that in consideration of the issuance to me of a license/certificate to practice in Louisiana, I swear that I shall observe, abide by and uphold the laws of the State of Louisiana governing my practice and that I shall abstain from unethical, deceptive and fraudulent methods of practice and from immoral, unprofessional and unethical conduct, and that I shall not associate professionally with nor become a partner or employee of any person who resorts to such practices. I hereby agree that the violation of this oath shall constitute cause sufficient for the revocation of said license/certificate and surrender of the rights and privileges accorded me thereunder.

Signed \_\_\_\_\_  
Full Name

Subscribed and sworn to before me this \_\_\_\_\_ day  
of \_\_\_\_\_ YEAR

\_\_\_\_\_  
NOTARY PUBLIC

My commission expires \_\_\_\_\_



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### CERTIFICATE OF DEAN/REGISTRAR

APPLICANT'S NAME

SOCIAL SECURITY NUMBER

**Section 1: To Applicant-**Complete Section 1 before a Notary. Forward this form to appropriate institution/employer.

#### **Recent photograph**

Passport quality photograph of applicant securely affixed. 2" x 2" clear, front view, full face without hat or dark glasses. Full-length photograph, black and white or computer-generated will not be accepted. Applicant is to sign name across bottom of photograph, partly on photograph and partly upon the page.

**Notary is to affix seal  
directly on photograph.**

**Affix Photograph**

**Here**

**(Follow directions carefully.)**

I certify that the photograph is a true likeness of \_\_\_\_\_ (Applicant).

On this the \_\_\_\_\_ Day of \_\_\_\_\_, 200\_\_\_\_\_

\_\_\_\_\_  
Notary Public

My commission expires \_\_\_\_\_

#### **Section 2: To Dean/Registrar**

After completion of this form, return to Office of Licensure, Louisiana State Board of Medical Examiners, P. O. Box 30250, New Orleans, LA 70190-0250. **DO NOT RETURN TO APPLICANT.**

I hereby certify that \_\_\_\_\_

Whose photograph appears above, was awarded the degree of, or certificate in, \_\_\_\_\_

Dated \_\_\_\_\_ from this school.

\_\_\_\_\_  
Name of school/program

\_\_\_\_\_  
Signature of Medical Dean/Registrar, Allied Program Chairman/Head

\_\_\_\_\_  
Address

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

*Affix School Seal Here*



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## THIRD PARTY AUTHORIZATION

### **Insert Full Name:**

I understand and acknowledge that the submission of an application to, as well as the acceptance or maintenance of, any license, permit, certificate and/or registration (hereinafter referred to as a "license") issued by the Louisiana State Board of Medical Examiners (the "Board") shall constitute and operate as a perpetual authorization by me to each educational institution at which I have matriculated, each state or federal agency to which I have applied for any license, permit, certificate and/or registration, each person, firm, corporation, clinic, office or institution by whom or with whom I have been employed in the practice of medicine or as an allied health professional, each physician or other health care practitioner whom I have consulted or seen for diagnosis or treatment and each professional organization or specialty board to which I have applied for membership, to disclose and release to the Board any and all information and documentation concerning me which the Board may deem material to the consideration of my initial application and during such period as I may hold or maintain a license. With respect to any such information or documentation, the submission of an application to or the acceptance or maintenance of a license from the Board shall equally constitute and operate as a consent by me to the disclosure and release of such information and documentation and as a waiver by me of any privilege or right of confidentiality which I would otherwise possess with respect thereto.

By submitting an application or accepting or maintaining a license issued by the Board, I shall be deemed to have given my consent to submit to physical or mental examinations if, when and in the manner so directed by the Board and to have waived all objections as to the admissibility or disclosure of findings, reports or recommendations pertaining thereto on the grounds of privileges provided by law. I acknowledge that the expense of any such examination shall be borne by me.

The submission of an application or the acceptance or maintenance of a license from the Board shall also constitute and operate as perpetual authorization and consent by me to the Board to disclose and release any information or documentation set forth in or submitted with my application, or which then or at any time thereafter may be obtained by the Board from other persons, firms, corporations, associations or governmental entities, to any person, firm, corporation, association or governmental entity having a lawful, legitimate and reasonable need therefore, including, without limitation, the medical and/or allied health professional licensing, permitting, certifying and/or registering authority of any state; the Federation of State Medical Boards of the United States; professional organizations, associations and societies; the American Medical Association and any component state, county or parish medical society, including but not limited to the Louisiana State Medical Society and component parish societies thereof; the American Osteopathic Association; the Louisiana Osteopathic Medical Association; the Federal Drug Enforcement Agency; the Louisiana Office of Narcotics and Dangerous Drugs, Office of Licensing and Registration, Department of Health and Hospitals; federal, state, county or parish and municipal health and law enforcement agencies and the Armed Services.

I understand that this authorization and consent is valid commencing on the date herein below subscribed and that such will remain in force and effect until and unless I withdraw my application for, or no longer possess or maintain, a license issued by the Board. I also acknowledge that a duplicate of this document may serve as an original.

Signature: \_\_\_\_\_  
Full Name

**\*\*TO BE SIGNED IN THE PRESENCE OF A NOTARY**

Subscribed and sworn to before me this \_\_\_\_\_ day

of \_\_\_\_\_, 20 \_\_\_\_\_.

\_\_\_\_\_  
Notary Public

*Seal*

MY COMMISSION EXPIRES: \_\_\_\_\_

# **Louisiana State Board of Medical Examiners**

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## ***REQUEST FOR EXAMINATION SCORES***

To request your scores be sent to us contact:

***BRPT Management Office***  
**8201 Greensboro Drive, Suite 300**  
**McLean, VA 22102**  
**Phone: (703) 610-9020**  
**Fax: (703) 610-9005**  
**<http://www.brpt.org/>**

**Contact the examination entity to determine monies necessary to request scores. The LSBME will not accept scores from any source other than the examination entity.**